City of Boulder

EXTRATERRITORIAL LEGISLATION

EFFECTIVE DATE: January 1, 2017

ETALLM17A
3338899

This document printed in November, 2016 takes the place of any documents previously issued to you which described your benefits.

Printed in U.S.A.

Table of Contents

CIGNA HEALTH AND LIFE INSURANCE COMPANY, a Cigna company (hereinafter called Cigna)

CERTIFICATE RIDER

Policyholder: City of Boulder
Rider Eligibility: Each Employee as noted within this certificate rider
Policy No. or Nos.: 3338899
Effective Date: January 1, 2017

This rider forms a part of the certificate issued to you by Cigna describing the benefits provided under the policy(ies) specified above. This rider replaces any other issued to you previously.

IMPORTANT INFORMATION

For Residents of States other than the State of Colorado:

State-specific riders contain provisions that may add to or change your certificate provisions.

The provisions identified in your state-specific rider, attached, are ONLY applicable to Employees residing in that state. The state for which the rider is applicable is identified at the beginning of each state specific rider in the "Rider Eligibility" section.

Additionally, the provisions identified in each state-specific rider only apply to:

(a) Benefit plans made available to you and/or your Dependents by your Employer;
(b) Benefit plans for which you and/or your Dependents are eligible;
(c) Benefit plans which you have elected for you and/or your Dependents;
(d) Benefit plans which are currently effective for you and/or your Dependents.

Please refer to the Table of Contents for the state-specific rider that is applicable for your residence state.

Anna Krishtul, Corporate Secretary

HC-ETRDR

CIGNA HEALTH AND LIFE INSURANCE COMPANY, a Cigna company (hereinafter called Cigna)

CERTIFICATE RIDER – Arizona Residents

Rider Eligibility: Each Employee who is located in Arizona

You will become insured on the date you become eligible, including if you are not in Active Service on that date due to your health status.

This rider forms a part of the certificate issued to you by Cigna.

The provisions set forth in this rider comply with the legal requirements of Arizona for group insurance plans covering insureds located in Arizona. These provisions supersede any provisions in your certificate to the contrary unless the provisions in your certificate result in greater benefits.

HC-ETAZRDR

Arizona

Important Notice

This notice is to advise you that you can obtain a replacement Appeals Process Information Packet by calling the Customer Service Department at the telephone number listed on your identification card for "Claim Questions/Eligibility Verification" or for "Member Services" or by calling 1-800-244-6224.

The Information Packet includes a description and explanation of the appeal process for Cigna.

Provider Lien Notice

Arizona law entitles health care providers to assert a lien for their customary charges for the care and treatment of an injured person upon any and all claims of liability or indemnity, except health insurance. If you are injured and have a claim against a non-health liability insurer (such as automobile or homeowner insurance) or any other payor source for injuries sustained, your health care provider may assert a lien against available proceeds from any such insurer or payor in an amount equal to the difference between the sum, if any, payable to the health care provider under this Plan and the health care provider's full billed charges.

Notice

This certificate of insurance may not provide all benefits and protections provided by law in Arizona. Please read this certificate carefully.

HC-IMP8 04-10

V1-ET

Eligibility - Effective Date

Employee Insurance

Late Entrant - Employee

You are a Late Entrant if:

- you elect the insurance more than 31 days after you become eligible; or
- you again elect it after you cancel your payroll deduction (if required).

Reinstatement of Benefits for Military Returnees

If your coverage ends when you are called to active duty and you are reemployed by your current Employer, coverage for you and your Dependents (including a Dependent born during the period of active military duty) may be reinstated if you applied for reinstatement within 90 days from the date of discharge or within one year of hospitalization continuing after discharge.

Dependent Insurance

Late Entrant – Dependent

You are a Late Entrant for Dependent Insurance if:

- you elect that insurance more than 31 days after you become eligible for it; or
- you again elect it after you cancel your payroll deduction (if required).

HC-ELG11 07-14

V3-ET1

Covered Expenses

- charges made for medical foods to treat inherited metabolic disorders. Metabolic disorders triggering medical food coverage are: part of the newborn screening program as prescribed by Arizona statute; involve amino acid, carbohydrate or fat metabolism; have medically standard methods of diagnosis, treatment and monitoring, including quantification of metabolites in blood, urine or spinal fluid or enzyme or DNA confirmation in tissues; and require specifically processed or treated medical foods that are generally available only under the supervision and direction

of a Physician, that must be consumed throughout life and without which the person may suffer serious mental or physical impairment.

For the purpose of this section, the following definitions apply:

- "Inherited Metabolic Disorder" means a disease caused by an inherited abnormality of body chemistry and includes a disease tested under the newborn screening program as prescribed by Arizona statute.
- "Medical Foods" means modified low protein foods and metabolic formula.
- "Metabolic Formula" means foods that are all of the following: formulated to be consumed or administered internally under the supervision of a medical doctor or doctor of osteopathy; processed or formulated to be deficient in one or more of the nutrients present in typical foodstuffs; administered for the medical and nutritional management of a person who has limited capacity to metabolize foodstuffs or certain nutrients contained in the foodstuffs or who has other specific nutrients requirements as established by medical evaluation; and essential to a person's optimal growth, health and metabolic homeostasis.
- "Modified Low Protein Foods" means foods that are all of the following: formulated to be consumed or administered internally under the supervision of a medical doctor or doctor of osteopathy; processed or formulated to contain less than one gram of protein per unit of serving, but does not include a natural food that is naturally low in protein; administered for the medical and nutritional management of a person who has limited capacity to metabolize foodstuffs or certain nutrients contained in the foodstuffs or who has other specific nutrients requirements as established by medical evaluation; and essential to a person's optimal growth, health and metabolic homeostasis.

HC-COV95 05-15
V5-ET

Definitions

Emergency Services

Out-of-Network

Emergency services are medical, psychiatric, surgical, Hospital and related health care services and testing, including ambulance service, which are required to treat a sudden, unexpected onset of a bodily Injury or serious Sickness which could reasonably be expected by a prudent layperson to result in serious medical complications, loss of life or permanent impairment to bodily functions in the absence of immediate medical attention. Examples of emergency situations include uncontrolled bleeding, seizures or loss of consciousness, shortness of breath, chest pains or severe squeezing sensations in the chest, suspected overdose of medication or poisoning, sudden paralysis or slurred speech, burns, cuts and broken bones. The symptoms that led you to believe you needed emergency care, as coded by the provider and recorded by the Hospital on the UB92 claim form, or its successor, or the final diagnosis, whichever reasonably indicated an emergency medical condition, will be the basis for the determination of coverage, provided such symptoms reasonably indicate an emergency. You are covered for at least a screening examination to determine whether an emergency exists. Care up and through stabilization for emergency situations will be covered without prior authorization.

Emergency Services

Emergency services means, with respect to an emergency medical condition, a medical screening examination that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate the emergency medical condition; and such further medical examination and treatment, to the extent they are within the capabilities of the staff and facilities available at the hospital, to stabilize the patient.

HC-DFS409 04-10
V1-ET

CIGNA HEALTH AND LIFE INSURANCE COMPANY, a Cigna company (hereinafter called Cigna)

CERTIFICATE RIDER – California Residents

Rider Eligibility: Each Employee who is located in California

You will become insured on the date you become eligible, including if you are not in Active Service on that date due to your health status.

This rider forms a part of the certificate issued to you by Cigna.

The provisions set forth in this rider comply with the legal requirements of California for group insurance plans covering insureds located in California. These provisions supersede any provisions in your certificate to the contrary unless the provisions in your certificate result in greater benefits.

HC-ETCARDR

Covered Expenses

- charges made for services related to the diagnosis, treatment, and management of osteoporosis. Covered services include, but are not limited to, all FDA approved technologies, including bone mass measurement technologies as deemed Medically Necessary.
- charges made for a drug that has been prescribed for purposes other than those approved by the FDA will be covered if:
  - the drug is otherwise approved by the FDA;
  - the drug is used to treat a life-threatening condition or, a chronic and seriously debilitating condition and the drug is Medically Necessary to treat that condition;
  - the drug has been recognized for the treatment prescribed by any of the following: the American Hospital Formulary Service Drug Information, one of the following compendia if recognized by the federal Centers for Medicare and Medicaid Services as part of an anticancer chemotherapeutic regimen: The Elsevier Gold Standard's Clinical Pharmacology; The National Comprehensive Cancer Network Drug and Biologics compendium; The Thomson Micromedix Drug Dex ; or two articles from major peer reviewed medical journals that present data supporting the proposed use or uses as generally safe and effective unless there is clear and convincing contradictory evidence presented in a major peer reviewed medical journal.
- charges for federal Food and Drug Administration (FDA)-approved prescription contraceptive methods, as designated by Cigna. If your Physician determines that none of the methods designated by Cigna are medically appropriate for you because of your medical or personal history, Cigna will cover the alternative FDA-approved prescription contraceptive prescribed by your Physician;

HC-COV441 05-15
HC-COV443 V1-ET1

Definitions

Dependent

Dependents include:

- your lawful spouse; or
- your Domestic Partner.

If your Domestic Partner has a child, that child will also be included as a Dependent.

HC-DFS158 04-10
V1-ET2

Domestic Partner

A Domestic Partner is defined as your Domestic Partner who has registered the domestic partnership by filing a Declaration of Domestic Partnership with the California Secretary of state pursuant to Section 298 of the Family Code or an equivalent document issued by a local agency of California, another state, or a local agency of another state under which the partnership was created.

HC-DFS159 04-10
V1-ET

CIGNA HEALTH AND LIFE INSURANCE COMPANY, a Cigna company (hereinafter called Cigna)

CERTIFICATE RIDER – Georgia Residents

Rider Eligibility: Each Employee who is located in Georgia

You will become insured on the date you become eligible, including if you are not in Active Service on that date due to your health status.

This rider forms a part of the certificate issued to you by Cigna.

The provisions set forth in this rider comply with the legal requirements of Georgia group insurance plans covering insureds located in Georgia. These provisions supersede any provisions in your certificate to the contrary unless the provisions in your certificate result in greater benefits.

HC-ETGARDR

Covered Expenses

- charges made for colorectal cancer screening, examinations and laboratory tests according to the most recently published guidelines and recommendations established by the American Cancer Society, in consultation with the American College of Gastroenterology and the American College of Radiology, if deemed appropriate by the Physician in consultation with the insured.

HC-COV503 11-15
V1-ET2

CIGNA HEALTH AND LIFE INSURANCE COMPANY, a Cigna company (hereinafter called Cigna)

CERTIFICATE RIDER – Illinois Residents

Rider Eligibility: Each Employee who is located in Illinois

You will become insured on the date you become eligible, including if you are not in Active Service on that date due to your health status.

This rider forms a part of the certificate issued to you by Cigna.

The provisions set forth in this rider comply with the legal requirements of Illinois group insurance plans covering insureds located in Illinois. These provisions supersede any provisions in your certificate to the contrary unless the provisions in your certificate result in greater benefits.

HC-ETILRDR

Important Notices

Illinois Notice

Notice to All Female Plan Members: Your Right to Select A Woman's Principal Health Care Provider

Illinois law allows you to select "a woman's principal health care provider" in addition to your selection of a Primary Care Physician. "A woman's principal health care provider" is a Physician licensed to practice medicine in all its branches specializing in obstetrics or gynecology or specializing in family practice. "A woman's principal health care provider" may be seen for care without referrals from your Primary Care Physician. If you have not already selected "a woman's principal health care provider," you may do so now or at any other time. You are not required to have or to select "a woman's principal health care provider."

Your "woman's principal health care provider" must be a part of your plan. You may get the list of participating obstetricians, gynecologists, and family practice specialists from your Employer's employee benefits coordinator, or for your own copy of the current list, you may call the toll-free Member Services number on your ID card. The list will be sent to you within 10 days after your call. To designate "a woman's principal health care provider" from the list, call the toll-free Member Services number on your ID card and tell our staff the name of the Physician you have selected.

HC-IMP14 04-10
V1-ET

The Schedule

If your medical plan is subject to a Lifetime Maximum or Preventive Care Maximum, The Schedule is amended to indicate that Mammogram charges do not accumulate towards those maximums. In addition, In-Network Preventive Care Related (i.e. “routine”) Mammograms will be covered at “No charge”.

SCHEDIL-ETC

Covered Expenses

- charges for colorectal cancer screening with sigmoidoscopy or fecal occult blood testing once every 3 years for: persons age 50 and older; or persons age 40 and older who are considered high risks for colorectal cancer.
- charges made for or in connection with low-dose mammography screening for detecting the presence of breast cancer. Coverage shall include: a baseline mammogram for women ages 35 to 39; an annual mammogram for women age 40 and older; and mammograms at intervals considered Medically Necessary for women less than age 40 who have a family history of breast cancer, prior personal history of breast cancer, positive genetic testing or other risk factors. Coverage also includes a comprehensive ultrasound screening of an entire breast or breasts if a mammogram demonstrates heterogeneous or dense breast tissue, when determined Medically Necessary by a Physician licensed to practice medicine in all of its branches.

- Low dose mammography means the x-ray examination of the breast using equipment dedicated specifically for mammography, including the x-ray tube, compression device and image receptor, with radiation exposure delivery of less than one rad per breast for two views of an average size breast.

- charges made for the removal of breast implants when the removal of the implant is Medically Necessary treatment for a sickness or injury.
- charges made for complete and thorough clinical breast exams performed by a Physician licensed to practice medicine in all its branches, an advanced practice nurse who has a collaborative agreement with a collaborating Physician that authorizes breast examinations, or a Physician assistant who has been delegated authority to provide breast examinations. Coverage shall include such an exam at least once every three years for women ages 20 to 40; and annually for women 40 years of age or older.

HC-COV430 08-15
V1-ET1

Definitions

Dependent – For Vision Benefits

Dependents include:

- your lawful spouse, including your civil union partner (The Religious Freedom Protection Act and Civil Union Act, 750 ILCS 75, allows both same-sex and different-sex couples to enter into a civil union with all of the obligations, protections, and legal rights that Illinois provides to married heterosexual couples).

HC-DFS799 07-15
V1-ET1

CIGNA HEALTH AND LIFE INSURANCE COMPANY, a Cigna company (hereinafter called Cigna)

CERTIFICATE RIDER – Indiana Residents

Rider Eligibility: Each Employee who is located in Indiana

You will become insured on the date you become eligible, including if you are not in Active Service on that date due to your health status.

This rider forms a part of the certificate issued to you by Cigna.

The provisions set forth in this rider comply with the legal requirements of Indiana group insurance plans covering insureds located in Indiana. These provisions supersede any provisions in your certificate to the contrary unless the provisions in your certificate result in greater benefits.

HC-ETINRDR

Indiana Notice

Cigna Health and Life Insurance Company Claim Offices Servicing Indiana

We are here to serve you.

As our certificate holder, your satisfaction is very important to us. If you have a question about your certificate, if you need assistance with a problem, or if you have a claim, you should first contact your Benefits Administrator or us at the numbers and addresses listed below. Should you have a valid claim, we fully expect to provide a fair settlement in a timely fashion.

Medical Questions

Cigna Health and Life Insurance Company
Midwest Claim Service Center
P.O. Box 2100
Bourbonnais, IL 60914 Tel. 1-800-Cigna24

Should you feel you are not being treated fairly with respect to a claim, you may contact the Indiana Department of Insurance with your complaint.

To contact the Department, write or call:

Consumer Services Division
Indiana Department of Insurance
311 West Washington Street, Suite 300
Indianapolis, IN 46204 – 2787
1-800-622-4461 or 1-317-232-2395

HC-IMP41 04-10
V1

Covered Expenses

- charges for reimbursement payments made to the Indiana First Steps program for Early Intervention Services incurred by a Dependent child enrolled in the program, from birth through age two. Payments made directly by the program will be credited toward deductibles or copayments.
- coverage for or in connection with expenses arising from medical and dental care (including orthodontic and oral surgery treatment) involved with the management of cleft lip and cleft palate.
- charges made for mammograms including, but not limited to:
  - a single baseline mammogram for women ages 35 through 39;
  - an annual mammogram for women under age 40 who are considered to be at risk;
  - an annual mammogram for women age 40 and over;
  - additional mammography views when necessary for proper evaluation; and
  - ultrasound services when considered by the treating Physician to be medically necessary.

HC-COV431 01-15
V2-ET2

Definitions

Dependent

The term child means a legally adopted child including: a child who has been placed with you for adoption provided the child is not removed from placement prior to legal adoption or a child for whom entry of an order granting custody to you has been made.

HC-DFS283 04-10
V2-ET

CIGNA HEALTH AND LIFE INSURANCE COMPANY, a Cigna company (hereinafter called Cigna)

CERTIFICATE RIDER – Iowa Residents

Rider Eligibility: Each Employee who is located in Iowa

You will become insured on the date you become eligible, including if you are not in Active Service on that date due to your health status.

This rider forms a part of the certificate issued to you by Cigna.

The provisions set forth in this rider comply with the legal requirements of Iowa group insurance plans covering insureds located in Iowa. These provisions supersede any provisions in your certificate to the contrary unless the provisions in your certificate result in greater benefits.

HC-ETIARDR

Medical Conversion Privilege

For You and Your Dependents

When a person's Medical Expense Insurance ceases, he may be eligible to be insured under an individual policy of medical care benefits (called the Converted Policy).

A Converted Policy will be issued by Cigna only to a person who:

- resides in a state that requires offering a conversion policy,
- is Entitled to Convert, and
- applies in writing and pays the first premium for the Converted Policy to Cigna within 31 days after the date his insurance ceases. Evidence of good health is not needed.

Employees Entitled to Convert

You are Entitled to Convert Medical Expense Insurance for yourself and all of your Dependents who were insured when your insurance ceased but only if following continuation of insurance as described in the section entitled, "Special Continuation of Medical Insurance":

- you are not eligible for other individual insurance coverage on a guaranteed issue basis.
- you have been insured for at least three consecutive months under the policy or under it and a prior policy issued to the Policyholder.

- your insurance ceased because you were no longer in Active Service or no longer eligible for Medical Expense Insurance.
- you were eligible for continuation and elected such continuation.
- you are not eligible for Medicare.
- you would not be Overinsured.
- you have paid all required premium or contribution.
- you have not performed an act or practice that constitutes fraud in connection with the coverage.
- you have not made an intentional misrepresentation of a material fact under the terms of the coverage.
- your insurance did not cease because the policy in its entirety canceled.

If you retire, you may apply for a Converted Policy within 31 days after your retirement date in place of any continuation of your insurance that may be available under this plan when you retire, if you are otherwise Entitled to Convert.

Dependents Entitled to Convert

The following Dependents are also Entitled to Convert:

- a child who is not eligible for other individual insurance coverage on a guaranteed issue basis, and whose insurance under this plan ceases because he no longer qualifies as a Dependent or because of your death;
- a spouse who is not eligible for other individual insurance coverage on a guaranteed issue basis, and whose insurance under this plan ceases due to divorce, annulment of marriage, or your death following continuation;
- your Dependents whose insurance under this plan ceases because your insurance ceased solely because you are eligible for Medicare;

but only if that Dependent: is not eligible for other individual insurance coverage on a guaranteed issue basis, is not eligible for Medicare, would not be Overinsured, has paid all required premium or contribution, has not performed an act or practice that constitutes fraud in connection with the coverage, and has not made an intentional misrepresentation of a material fact under the terms of the coverage.

Overinsured

A person will be considered Overinsured if either of the following occurs:

- his insurance under this plan is replaced by similar group coverage within 31 days.
- the benefits under the Converted Policy, combined with Similar Benefits, result in an excess of insurance based on Cigna's underwriting standards for individual policies.

Similar Benefits are: those for which the person is covered by another hospital, surgical or medical expense insurance policy, or a hospital, or medical service subscriber contract, or a medical practice or other prepayment plan or by any other plan or program; those for which the person is eligible, whether or not covered, under any plan of group coverage on an insured or uninsured basis; or those available for the person by or through any state, provincial or federal law.

Converted Policy

If you reside in a state that requires the offering of a conversion policy, the Converted Policy will be one of Cigna's current conversion policy offerings available in the state where you reside, as determined based upon Cigna's rules.

The Converted Policy will be issued to you if you are Entitled to Convert, insuring you and those Dependents for whom you may convert. If you are not Entitled to Convert and your spouse and children are Entitled to Convert, it will be issued to the spouse, covering all such Dependents. Otherwise, a Converted Policy will be issued to each Dependent who is Entitled to Convert. The Converted Policy will take effect on the day after the person's insurance under this plan ceases. The premium on its effective date will be based on: class of risk and age; and benefits.

During the first 12 months the Converted Policy is in effect, the amount payable under it will be reduced so that the total amount payable under the Converted Policy and the Medical Benefits Extension of this plan (if any) will not be more than the amount that would have been payable under this plan if the person's insurance had not ceased. After that, the amount payable under the Converted Policy will be reduced by any amount still payable under the Medical Benefits Extension of this plan (if any). Cigna or the Policyholder will give you, on request, further details of the Converted Policy.

HC-CNV31 04-14
V1-ET

CIGNA HEALTH AND LIFE INSURANCE COMPANY, a Cigna company (hereinafter called Cigna)

CERTIFICATE RIDER – Minnesota Residents

Rider Eligibility: Each Employee who is located in Minnesota

You will become insured on the date you become eligible, including if you are not in Active Service on that date due to your health status.

This rider forms a part of the certificate issued to you by Cigna.

The provisions set forth in this rider comply with the legal requirements of Minnesota group insurance plans covering insureds located in Minnesota. These provisions supersede any provisions in your certificate to the contrary unless the provisions in your certificate result in greater benefits.

HC-ETMNRDR

Eligibility – Effective Date

Dependent Insurance

Effective Date of Dependent Insurance

If you are a Late Entrant for Dependent Insurance, the insurance for each of your Dependents will not become effective until Cigna agrees to insure that Dependent. However, failure to elect insurance for disabled Dependents will not cause you to be considered a Late Entrant for Dependent Insurance and you may elect to insure them at any time.

Your Dependents will be insured only if you are insured.

Late Entrant – Dependent

You are a Late Entrant for Dependent Insurance if:

- you elect that insurance more than 30 days after you become eligible for it; or
- you again elect it after you cancel your payroll deduction (if required).

HC-ELG140 10-15
ET

Covered Expenses

- charges made for routine procedures for cancer screening, including mammograms, Papanicolaou tests, colorectal screening tests for men and women, and ovarian cancer screening for women considered at risk due to a prior positive test for BRCA1 or BRCA2 mutations; or a family history of: one or more first or second degree relatives with ovarian cancers; clusters of women relatives with breast cancer; or nonpolyposis colorectal cancer.
- charges made for hearing aids, including but not limited to semi-implantable hearing devices, audient bone conductors and Bone Anchored Hearing Aids (BAHAs). A hearing aid is any device that amplifies sound. Coverage is limited to one hearing aid per ear every three years, up to age 18.
- charges for general anesthesia and for associated Hospital or facility charges for dental care for your Dependent child who is under the age of five (5) or who is severely disabled, or who has a medical condition and requires hospitalization or general anesthesia for dental care treatment. Pre-authorization of hospitalization is required. Coverage may also include general anesthesia and treatment provided by a licensed Dentist for a covered medical condition, regardless if the services are provided in a hospital or in a dental office.

Clinical Trials

This benefit plan covers routine patient care costs related to an approved Phase I, II, III or IV clinical trial for an individual who meets the following requirements:

(a) is eligible to participate in an approved clinical trial according to the trial protocol with respect to prevention, detection or treatment of cancer or other life-threatening disease or condition; and

(b) either

- the referring health care professional is a participating health care provider and has concluded that the individual's participation in such trial would be appropriate based upon the individual meeting the conditions described in paragraph (a); or
- the individual provides medical and scientific information establishing that the individual's participation in such trial would be appropriate based upon the individual meeting the conditions described in paragraph (a).

For purposes of clinical trials, the term "life-threatening disease or condition" means any disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted.

The clinical trial must meet the following requirements:

- The study or investigation must:

- be approved or funded by any of the agencies or entities authorized by federal law to conduct clinical trials;
- be conducted under an investigational new drug application reviewed by the Food and Drug Administration; or
- involve a drug trial that is exempt from having such an investigational new drug application.

Routine patient care costs are costs associated with the provision of health care items and services including drugs, items, devices and services otherwise covered by this benefit plan for an individual who is not enrolled in a clinical trial and, in addition:

- services required solely for the provision of the investigational drug, item, device or service;
- services required for the clinically appropriate monitoring of the investigational drug, device, item or service;
- services provided for the prevention of complications arising from the provision of the investigational drug, device, item or service; and
- reasonable and necessary care arising from the provision of the investigational drug, device, item or service, including the diagnosis or treatment of complications.

Routine patient care costs do not include:

- the investigational drug, item, device, or service that is part of the trial itself; or
- items and services that are provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient.

If your plan includes In-Network providers, clinical trials conducted by non-participating providers will be covered at the In-Network benefit level if:

- there are no In-Network providers participating in the clinical trial that are willing to accept the individual as a patient, or
- the clinical trial is conducted outside the individual's state of residence.

HC-COV386 01-15
HC-COV387 V1-ET4

Exclusions, Expenses Not Covered and General Limitations

Exclusions and Expenses Not Covered

The following Exclusion does not apply, if found in the Exclusion section of your medical certificate:

- transsexual surgery including medical or psychological counseling and hormonal therapy in preparation for, or subsequent to, any such surgery.

HC-EXC145 10-15
ET

Termination of Insurance

Employees

Your insurance will cease on the last day of the month of the earliest date below:

- the date you cease to be in a Class of Eligible Employees or cease to qualify for the insurance.
- the last day for which you have made any required contribution for the insurance.
- the date the policy is canceled.
- the date your Active Service ends except as described below.

Any continuation of insurance must be based on a plan which precludes individual selection.

Dependents

Your insurance for all of your Dependents will cease on the last day of the month of the earliest date below:

- the date your insurance ceases.
- the date you cease to be eligible for Dependent Insurance.
- the last day for which you have made any required contribution for the insurance.
- the date Dependent Insurance is canceled.

The insurance for any one of your Dependents will cease on the date that Dependent no longer qualifies as a Dependent.

HC-TRM1 01-15
V8 ET

Termination of Insurance and Special Continuation

Reinstatement of Insurance

If your coverage ceases because of active duty in: the armed forces of the United States, or the National Guard, the insurance for you and your Dependents will be reinstated after your deactivation, provided that:

- you apply for such reinstatement within 90 days after deactivation; and
- you are otherwise eligible.

Such reinstatement will be without the application of: a new waiting period, or a new Pre-existing Condition Limitation. A new Pre-existing Condition Limitation will not be applied to a condition that you or your Dependent may have developed while coverage was interrupted, excluding any condition that the Veterans Administration has determined to be military related. The remainder of a Pre-existing Condition Limitation which existed prior to interruption of coverage may still be applied.

HC-TRM70 09-14

V2-ET1

Medical Benefits Extension During Hospital Confinement Upon Policy Cancellation

If the Medical Benefits under this plan cease for you or your Dependent due to cancellation of the Policy, and you or your Dependent is Confined in a Hospital on that date, Medical Benefits will be paid without requirement of premium for Covered Expenses incurred in connection with that Hospital Confinement. However, no benefits will be paid after the earliest of:

- the date you exceed the Maximum Benefit, if any, shown in the Schedule;
- the date you are covered for medical benefits under another group plan; or
- the date you or your Dependent is no longer Hospital Confined;

The terms of this Medical Benefits Extension will not apply to a child born as a result of a pregnancy which exists when your or your Dependent's Medical Benefits cease.

HC-BEX36 04-10

V1-ET

CIGNA HEALTH AND LIFE INSURANCE COMPANY, a Cigna company (hereinafter called Cigna)

CERTIFICATE RIDER – Nebraska Residents

Rider Eligibility: Each Employee who is located in Nebraska

You will become insured on the date you become eligible, including if you are not in Active Service on that date due to your health status.

This rider forms a part of the certificate issued to you by Cigna.

The provisions set forth in this rider comply with the legal requirements of Nebraska group insurance plans covering insureds located in Nebraska. These provisions supersede any provisions in your certificate to the contrary unless the provisions in your certificate result in greater benefits.

HC-ETNERDR

Covered Expenses

- charges made for one screening test for hearing loss for a Dependent child from birth through 30 days old.
- charges for the screening, diagnosis, and treatment of autism spectrum disorder.

  Treatment means evidence-based care, including related equipment, that is prescribed or ordered for a covered person diagnosed with an autism spectrum disorder by a licensed Physician or a licensed Psychologist including: Behavioral health treatment; pharmacy care; psychiatric care; psychological care, and therapeutic care.

Behavioral health treatment means counseling and treatment programs, including applied behavior analysis, that are: necessary to develop, maintain, or restore, to the maximum extent practicable, the functioning of an individual; and provided by a certified behavior analyst or a licensed Psychologist if the services performed are within the boundaries of the Psychologist's competency.

Pharmacy care means a medication that is prescribed by a licensed Physician and any health related service deemed Medically Necessary to determine the need or effectiveness of the medication.

Psychiatric care means a direct or consultative service provided by a psychiatrist licensed in the state in which he or she practices.

Psychological care means a direct or consultative service provided by a Psychologist licensed in the state in which he or she practices.

Therapeutic care means a service provided by a licensed speech-language pathologist, occupational therapist, or physical therapist.

HC-COV469 05-15
V1-ET

CIGNA HEALTH AND LIFE INSURANCE COMPANY, a Cigna company (hereinafter called Cigna)

CERTIFICATE RIDER – Nevada Residents

Rider Eligibility: Each Employee who is located in Nevada

You will become insured on the date you become eligible, including if you are not in Active Service on that date due to your health status.

This rider forms a part of the certificate issued to you by Cigna.

The provisions set forth in this rider comply with the legal requirements of Nevada group insurance plans covering insureds located in Nevada. These provisions supersede any provisions in your certificate to the contrary unless the provisions in your certificate result in greater benefits.

HC-ETNVRDR

Important Notices

Nevada Division of Insurance

You can contact the Nevada Division of Insurance at the following:

The Department of Business Industry, Division of Insurance

Toll free number: (888) 872-3234

Hours of operation of the division: Mondays through Fridays from 8:00 a.m. until 5:00 p.m., Pacific Standard Time (PST).

If you have local telephone access to the Carson City and Las Vegas offices of the Division of Insurance, you should call the local numbers.

Local telephone numbers are: Carson City, **702-687-4270** and Las Vegas, **702-486-4009**

HC-IMP48 04-10
V2-ET

Covered Expenses

- charges for a drug that has been prescribed for the treatment of cancer for which use of the drug has not been approved by the U.S. Food and Drug Administration if that drug has been recognized as a treatment for cancer by either the American Hospital Formulary Services Drug Information; US Pharmacopoeia Drug Information; or supported by at least two articles published in accepted scientific medical journals. Coverage will also be provided for any medical services necessary to administer the drug.

HC-COV489 01-16
ET

HC-COV187

Definitions

If Domestic Partners are covered under the plan, then the following applies:

Domestic Partner

A Domestic Partner is defined as a person of the same or opposite sex who:

- shares your permanent residence;
- has resided with you for no less than one year;
- is no less than 18 years of age;
- is financially interdependent with you and has proven such interdependence by providing documentation of at least two of the following arrangements: common ownership of real

property or a common leasehold interest in such property; community ownership of a motor vehicle; a joint bank account or a joint credit account; designation as a beneficiary for life insurance or retirement benefits or under your partner's will; assignment of a durable power of attorney or health care power of attorney; or such other proof as is considered by Cigna to be sufficient to establish financial interdependency under the circumstances of your particular case;

- is not a blood relative any closer than would prohibit legal marriage; and
- has signed jointly with you, a notarized affidavit attesting to the above which can be made available to Cigna upon request.

In addition, you and your Domestic Partner will be considered to have met the terms of this definition as long as neither you nor your Domestic Partner:

- has signed a Domestic Partner affidavit or declaration with any other person within twelve months prior to designating each other as Domestic Partners hereunder;
- is currently legally married to another person; or
- has any other Domestic Partner, spouse or spouse equivalent of the same or opposite sex.

You and your Domestic Partner must have registered as Domestic Partners, if you reside in a state that provides for such registration.

The section of this certificate entitled "COBRA Continuation Rights Under Federal Law" will not apply to your Domestic Partner and his or her Dependents.

HC-DFS223 04-10
V2-ET

CIGNA HEALTH AND LIFE INSURANCE COMPANY, a Cigna company (hereinafter called Cigna)

CERTIFICATE RIDER – New Jersey Residents

Rider Eligibility: Each Employee who is located in New Jersey

You will become insured on the date you become eligible, including if you are not in Active Service on that date due to your health status.

This rider forms a part of the certificate issued to you by Cigna.

The provisions set forth in this rider comply with the legal requirements of New Jersey group insurance plans covering insureds located in New Jersey. These provisions supersede any provisions in your certificate to the contrary unless the provisions in your certificate result in greater benefits.

HC-ETNJRDR

Important Notice

Your health plan provides that you will not be held financially liable for payments to health care providers for any sums, other than required copayments, coinsurance or deductibles, owed for covered expenses, if Cigna fails to pay for the covered expenses for any reason.

HC-IMP17 04-10
V1-ET

Covered Expenses

Covered Expenses include charges for childhood immunizations as recommended by the Advisory Committee on Immunization practices of the U.S. Public Health Service, the Department of Health and the New Jersey Department of Health and Senior Services for a Dependent child during that child’s lifetime. Any In-Network deductible will be waived for childhood immunizations.

HC-COV42 04-10
V1-ET

Definitions

Dependent

Dependents include:

- your lawful spouse or civil union partner; or
- any child of yours who is:
  - less than 26 years old.
  - 26 years old, but less than 26, not married nor in a civil union partnership nor in a Domestic Partnership, enrolled in school as a full-time student and primarily supported by you.
  - 26 or more years old, not married nor in a civil union partnership nor in a Domestic Partnership, and primarily supported by you and incapable of self-sustaining employment by reason of mental or physical disability which arose while the child was covered as a Dependent under this Plan, or while covered as a dependent under a prior plan with no break in coverage.

    Proof of the child's condition and dependence must be submitted to Cigna within 31 days after the date the child ceases to qualify above. From time to time, but not more frequently than once a year, Cigna may require proof of the continuation of such condition and dependence.

The term child means a child born to you or a child legally adopted by you. It also includes a stepchild. If your civil union partner has a child, that child will also be included as a Dependent.

HC-DFS646 01-15
V1-ET

Medically Necessary/Medical Necessity

Medically Necessary Covered Services and Supplies means or describes a health care service that a health care provider, exercising his prudent clinical judgment, would provide to a covered person for the purpose of evaluating, diagnosing or treating an illness, injury, disease or its symptoms and that is: in accordance with the generally accepted standards of medical practice; clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the covered person's illness, injury or disease; not primarily for the convenience of the covered person or the health care provider; and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that covered person's illness, injury or disease.

HC-DFS113 04-10
V1-ET

CIGNA HEALTH AND LIFE INSURANCE COMPANY, a Cigna company (hereinafter called Cigna)

CERTIFICATE RIDER – Ohio Residents

Rider Eligibility: Each Employee who is located in Ohio

You will become insured on the date you become eligible, including if you are not in Active Service on that date due to your health status.

This rider forms a part of the certificate issued to you by Cigna.

The provisions set forth in this rider comply with the legal requirements of Ohio group insurance plans covering insureds located in Ohio. These provisions supersede any provisions in your certificate to the contrary unless the provisions in your certificate result in greater benefits.

HC-ETOHRDR

Eligibility - Effective Date

Dependent Insurance

Exception for Newborns

Newborns are automatically covered for the first 31 days after birth. In order to continue the child's coverage after the end of that 31-day period, you must elect to insure your newborn child within 31 days after the date of birth. If you do not elect to insure your newborn child within such 31 days, coverage for that child will end on the 31st day. No benefits for expenses incurred beyond the 31st day will be payable.

HC-ELG70
HC-ELG61 04-10
V1-ET

Covered Expenses

- charges made for or in connection with: an annual cytologic screening (Pap smear) for detection of cervical cancer; a single baseline mammogram for women ages 35 to 39; a mammogram every two years for women ages 40 through 49, or an annual mammogram if a licensed Physician has

determined the woman to be at risk; and an annual mammogram for women ages 50 through 64.

- Medical, surgical and Hospital care during the term of pregnancy, upon delivery and during the postpartum period for normal delivery, spontaneous abortion (miscarriage) and complications of pregnancy. Coverage for a mother and her newborn child shall be available for a minimum of 48 hours of inpatient care following a vaginal delivery and a minimum of 96 hours of inpatient care following a cesarean section. Any decision to shorten the period of inpatient care for the mother or the newborn must be made by the attending Physician or nurse-midwife in consultation with the mother. If you and your newborn receive at least 48 or 96 hours of inpatient stay following a vaginal or cesarean section, respectively, then coverage will be provided for physician-directed follow-up care that is determined Medically Necessary by the attending health care professionals. If you and your newborn are discharged earlier than the 48 or 96 hours described above, coverage will be provided for all Physician-directed follow-up care provided within 72 hours. Follow-up care shall include physical assessment of you and your newborn, parent education, assistance and training in breast or bottle feeding, assessment of the home support system, performance of clinical tests and any other services that are consistent with the follow-up care recommended in the protocols and guidelines developed by the national organizations that represent pediatric, obstetric and nursing professionals. The coverage shall apply to services provided in your Physician's office or through home care visits. Home health care visits must be conducted by a provider who is knowledgeable and experienced in maternity and newborn care.
- charges for any drug approved by the Food and Drug Administration (FDA) which has not been approved by the FDA for the treatment of the particular indication for which the drug has been prescribed, provided the drug has been recognized as safe and effective for treatment of that indication in one or more of the standard medical reference compendia adopted by the Department of Health and Human Services (HHS) under 42 U.S.C. 1395x(t)(2), as amended, or in medical literature only if all of the following apply:
  - Two articles from major peer-reviewed professional medical journals have recognized, based on scientific or medical criteria, the drug's safety and effectiveness for treatment of the indication for which it has been prescribed;
  - No article from a major peer-reviewed professional medical journal has concluded, based on scientific or medical criteria, that the drug is unsafe or ineffective or that the drug's safety and effectiveness cannot be determined for the treatment of the indication for which it has been prescribed;
  - Each article meets the uniform requirements for manuscripts submitted to biomedical journals established by the international committee of medical journal editors or is published in a journal specified by the HHS pursuant to section 1861(t)(2)(B) of the "Social Security Act," 107 Stat. 591 (1993), 42 U.S.C. 1395x(t)(2)(B), as amended, as acceptable peer-reviewed medical literature.

  Coverage includes Medically Necessary services associated with the administration of the drug.

  Such coverage shall not be construed to do any of the following:
  - Require coverage for any drug if the FDA has determined its use to be contraindicated for the treatment of the particular indication for which the drug has been prescribed;
  - Require coverage for experimental drugs not approved for any indication by the FDA;
  - Alter any law with regard to provisions limiting the coverage of drugs that have not been approved by the FDA;
  - Require reimbursement or coverage for any drug not included in the drug formulary or list of covered drugs specified in the policy;
  - Prohibit Cigna from limiting or excluding coverage of a drug, provided that the decision to limit or exclude coverage of the drug is not based primarily on the coverage of drugs described in this provision.

HC-COV123
HC-COV124 04-10
V1-ET1

Clinical Trials

- charges made for Routine Patient Care administered to an insured person participating in any stage of an Eligible Cancer Clinical Trial if that care would be covered under the plan if the insured was not participating in the trial.

  Eligible Cancer Clinical Trial means a cancer clinical trial that meets all of the following criteria:
  - A purpose of the trial is to test whether the intervention potentially improves the trial participant's health outcomes.
  - the treatment provided as part of the trial is given with the intention of improving the trial participant's health outcomes.

- the trial has a therapeutic intent and is not designed exclusively to text toxicity or disease pathophysiology.
- the trial does one of the following:
  - tests how to administer a health care service, item or drug for the treatment of cancer;
  - tests responses to a health care service, item or drug for the treatment of cancer;
  - compares the effectiveness of a health care service, item or drug for the treatment of cancer;
  - studies new uses of a health care service, item or drug for the treatment of cancer.
- the trial is approved by one of the following entities:
  - the National Institutes of Health or one of its cooperative groups or centers under the United States Department of Health and Human Services;
  - the United States Food and Drug Administration;
  - The United States Department of Defense; or
  - The United States Department of Veterans' Affairs.

Coverage for cancer clinical trials is subject to all terms, conditions, exclusions and limitations that apply to any other coverage under the plan for services performed by participating and nonparticipating providers.

Routine Patient Care means all health care services consistent with the coverage provided in the health benefit plan for the treatment of cancer, including the type and frequency of any diagnostic modality, that is typically covered for a cancer patient who is not enrolled in a cancer clinical trial and that was not necessitated solely because of the trial.

Routine Patient Care does not include, and reimbursement will not be provided for:

- A health care service, item or drug that is the subject of the cancer clinical trial (i.e. the service, item or drug that is being evaluated in the clinical trial and that is not Routine Patient Care);
- A health care service, item or drug provided solely to satisfy data collection and analysis needs for the cancer clinical trial that is not used in the direct clinical management of the patient;
- An investigational or experimental drug or device that has not been approved for market by the U.S. Food and Drug Administration;
- Transportation, lodging, food or other expenses for the patient, or a family member or companion of the patient, that are associated with the travel to or from a facility providing the cancer clinical trial;
- An item or drug provided by the cancer clinical trial sponsors free of charge for any patient; or
- A service, item or drug that is eligible for reimbursement by a person other than the carrier, including the sponsor of the cancer clinical trial.

HC-COV123
HC-COV124 04-10
V1-ET2

Medical Conversion Privilege

For You and Your Dependents

When a person's Medical Expense Insurance ceases, he may be eligible to be insured under an individual policy of medical care benefits (called the Converted Policy).

A Converted Policy will be issued on a direct-payment basis by Cigna only to a person who is Entitled to Convert, and only if he applies in writing and pays the first premium for the Converted Policy to Cigna within 31 days after the date his insurance ceases. Evidence of good health is not needed.

Employees Entitled to Convert

You are Entitled To Convert Medical Expense Insurance for yourself and all of your Dependents who were insured when your insurance ceased, except a Dependent who is eligible for Medicare or would be Overinsured, but only if:

- you have been insured for at least three consecutive months under the policy or under it and a prior policy issued to the Policyholder.
- your insurance ceased because you were no longer in Active Service or no longer eligible for Medical Expense Insurance.
- you are not eligible for Medicare.
- you would not be Overinsured.
- you have paid all required premium or contribution.
- you have not performed an act or practice that constitutes fraud in connection with the coverage.
- you have not made an intentional misrepresentation of a material fact under the terms of the coverage.
- your insurance did not cease because the policy in its entirety canceled.

If you retire you may apply for a Converted Policy within 31 days after your retirement date in place of any continuation of your insurance that may be available under this plan when you retire, if you are otherwise Entitled to Convert.

Dependents Entitled to Convert

The following Dependents are also Entitled to Convert:

- a child whose insurance under this plan ceases because he no longer qualifies as a Dependent or because of your death;

- a spouse whose insurance under this plan ceases due to divorce, annulment of marriage or your death;
- your Dependents whose insurance under this plan ceases because your insurance ceased solely because you are eligible for Medicare;

but only if that Dependent: is not eligible for Medicare; would not be Overinsured, has paid all required premium or contribution, has not performed an act or practice that constitutes fraud in connection with the coverage, and has not made an intentional misrepresentation of a material fact under the terms of the coverage.

Overinsured

A person will be considered Overinsured if either of the following occurs:

- his insurance under this plan is replaced by similar group coverage within 31 days.
- the benefits under the Converted Policy, combined with Similar Benefits, result in an excess of insurance based on Cigna's underwriting standards for individual policies.

  Similar Benefits are: those for which the person is covered by another hospital, surgical or medical expense insurance policy, or a hospital, or medical service subscriber contract, or a medical practice or other prepayment plan or by any other plan or program; those for which the person is eligible, whether or not covered, under any plan of group coverage on an insured or uninsured basis; or those available for the person by or through any state, provincial or federal law.

Converted Policy

The Converted Policy will be one of Cigna's current offerings at the time the first premium is received based on its rules for Converted Policies. The Converted Policy will be on a form which meets the conversion requirements of the jurisdiction where you reside, if a Converted Policy is permitted by such jurisdiction, and there is no alternative state program available.

The Converted Policy will be issued to you if you are Entitled to Convert, insuring you and those Dependents for whom you may convert. If you are not Entitled to Convert and your spouse and children are, it will be issued to the spouse, covering all such Dependents. Otherwise, a Converted Policy will be issued to each Dependent who is Entitled to Convert. The Converted Policy will take effect on the day after the person's insurance under this plan ceases. The premium on its effective date will be based on: class of risk and age; and benefits.

The Converted Policy may not exclude any pre-existing condition not excluded by this plan. During the first 12 months the Converted Policy is in effect, the amount payable under it will be reduced so that the total amount payable under the Converted Policy and the Medical Benefits Extension of this plan (if any) will not be more than the amount that would have been payable under this plan if the person's insurance had not ceased. After that, the amount payable under the Converted Policy will be reduced by any amount still payable under the Medical Benefits Extension of this plan (if any). Cigna or the Policyholder will give you, on request, further details of the Converted Policy.

HC-CNV26
HC-CNV27 04-10
V1-ET

Termination of Insurance

Special Continuation of Medical Insurance for Military Reservists and Their Dependents

If you are a Reservist, and if your Medical Insurance would otherwise cease because you are called or ordered to active military duty, you may continue Medical Insurance for yourself and your Dependents, upon payment of the required premium to your Employer, until the earliest of the following dates:

- 18 months from the date your insurance would otherwise cease, except that coverage for a Dependent may be extended to 36 months as provided in the section below entitled “Extension of Continuation to 36 months”;
- the last day for which the required premium has been paid;
- the date you or your Dependent becomes eligible for insurance under another group policy that does not contain any pre-existing condition limitation, other than the Civilian Health and Medical Program of the Uniformed Services;
- the date the group policy is cancelled.

The continuation of Medical Insurance will provide the same benefits as those provided to any similarly situated person insured under the policy who has not been called to active duty.

“Reservist” means a member of a reserve component of the armed forces of the United States. “Reservist” includes a member of the Ohio National Guard and the Ohio Air National Guard.

Extension of Continuation to 36 Months

If your Dependent’s insurance is being continued as outlined above, such Dependent may extend the 18-month continuation to a total of 36 months if any of the following occur during the original 18-month period:

- you die;
- you are divorced or legally separated from your spouse; or

- your Dependent ceases to qualify as an eligible Dependent under the policy.

Provisions Regarding Notification and Election of Special Continuation

Your Employer will notify you of your right to elect continuation of Medical Insurance. To elect the continuation, you or your Dependent must notify the Employer and pay the required premium within 31 days after the date your insurance would otherwise cease, or within 31 days after the date you are notified of your right to continue, if later.

Special Continuation of Medical Insurance

If your Active Service ends because of involuntary termination of employment, and if:

- you have been insured under the policy (or under the policy and any similar group coverage replaced by the policy) during the entire 3 months prior to the date your Active Service ends; and
- you pay the Employer the required premium;

your Medical Insurance will be continued until:

- you become eligible for similar group medical benefits or for Medicare;
- the last day for which you have made the required payment;
- 12 months from the date your Active Service ends; or
- the date the policy cancels;

whichever occurs first.

At the time you are given notice of termination of employment, your Employer will give you written notice of your right to continue the insurance. To elect this option, you must apply in writing and make the required monthly payment to the Employer within 31 days after the date your Active Service ends.

If your insurance is being continued under this section, the Medical Insurance for Dependents insured on the date your insurance would otherwise cease may be continued, subject to the provisions of this section. The insurance for your Dependents will be continued until the earlier of:

- the date your insurance for yourself ceases; or
- with respect to any one Dependent, the date that Dependent no longer qualifies as a Dependent.

This option will not reduce any continuation of insurance otherwise provided.

Dependent Medical Insurance After Divorce

In the case of divorce, annulment, dissolution of marriage or legal separation you may be required to continue the insurance for any one of your Dependents.

Conversion Available After Continuation

The provisions of the "Medical Conversion Privilege" section will apply when the insurance ceases.

HC-TRM48 04-10
V1-ET

Termination of Insurance

Cancellation or Nonrenewal

Your coverage may be cancelled or nonrenewed by Cigna if you have performed an act or practice that constitutes fraud or intentional misrepresentation of material fact under the terms of your coverage and if the cancellation or nonrenewal is not based, either directly or indirectly, on any health status-related factor in relation to you.

HC-TRM92 04-10
V1-ET

Medical Benefits Extension

Coverage will continue to be provided while you are confined to a Hospital following termination of coverage. Coverage will be provided for the specific medical condition causing the confinement and any other Medically Necessary treatment during that period of confinement.

This extension of coverage will end on the earliest of the following:

- the date the insured is discharged from the Hospital;
- the date the insured's attending Physician determines that the Hospital Confinement is no longer Medically Necessary;
- the date the insured exhausts the coverage available for the confinement and/or medical condition; or
- the effective date of coverage for the insured under another policy, plan or contract.

The terms of this Medical Benefits Extension will not apply to a child born as a result of a pregnancy which exists when a person's benefits cease.

HC-BEX31 04-10
V1-ET

Definitions

Dependent

A child includes an adopted child including that child from the first day of placement in your home regardless of whether the adoption has become final.

HC-DFS272 04-10
V2-ET

CIGNA HEALTH AND LIFE INSURANCE COMPANY, a Cigna company (hereinafter called Cigna)

CERTIFICATE RIDER – Oregon Residents

Rider Eligibility: Each Employee who is located in Oregon

You will become insured on the date you become eligible, including if you are not in Active Service on that date due to your health status.

This rider forms a part of the certificate issued to you by Cigna.

The provisions set forth in this rider comply with the legal requirements of Oregon group insurance plans covering insureds located in Oregon. These provisions supersede any provisions in your certificate to the contrary unless the provisions in your certificate result in greater benefits.

HC-ORM-04-11 HC-ETORRDR

Eligibility – Effective Date

Exception to Late Entrant Definition

A person will not be considered a Late Entrant when enrolling outside a designated enrollment period if: he had existing coverage, and he certified in writing, if applicable, that he declined coverage due to other available coverage; Employer contributions toward the other coverage have been terminated; he no longer qualifies in an eligible class for prior coverage; or if such prior coverage was continuation coverage and the continuation period has been exhausted; and he enrolls for this coverage within 30 days after losing or exhausting prior coverage; or if he is a Dependent spouse or minor child enrolled due to court order, within 30 days after the order is issued.

If you acquire a new Dependent through marriage, birth, adoption or placement for adoption, you may enroll your eligible Dependents and yourself, if you are not already enrolled, within 30 days of such event. Coverage will be effective, on the date of marriage, birth, adoption, or placement for adoption.

An adopted child, or a child placed for adoption before age 19 will not be subject to any Pre-existing Condition limitation if such child was covered within 30 days of adoption or placement for adoption. Such waiver will not apply if 63 days elapse between coverage during a prior period of Creditable Coverage and coverage under this plan.

Any applicable Pre-existing Condition limitation will apply to you and your Dependents upon enrollment, reduced by prior Creditable Coverage, but will not be extended as for a Late Entrant.

Pre-Existing Condition Limitation for Late Entrant

For plans which include a Pre-existing Condition limitation, the 6-month waiting period before coverage begins for such conditions, will be increased to 12 months for a Late Entrant.

For plans which do not include a Pre-existing Condition limitation, you may be required to wait until the next plan enrollment period, but no longer than 12 months, to enroll for coverage under the plan, if you are a Late Entrant.

For plans which do not standardly include a Pre-existing Condition limitation and which do not include an annual open enrollment period, a Pre-existing condition limitation of 12 months will apply for a Late Entrant.

HC-ELG5 04-10
V1-ET

Certification Requirements

For You and Your Dependents

Pre-Admission Certification/Continued Stay Review for Hospital Confinement

Any PAC determination will be binding on Cigna for:

- the lesser of: 5 business days; or in the event your coverage will terminate sooner than 5 business days, the period your coverage remains in effect, provided that when PAC is authorized:
  - Cigna has specific knowledge that your coverage will terminate sooner than 5 business days; and
  - the termination date is specified in the PAC; or
- the time period your coverage remains in effect, subject to a maximum of 30 calendar days.

For purposes of counting days, day 1 occurs on the first business or calendar day, as applicable, following the day on which Cigna issues a PAC.

Cigna will respond to a PAC request for a non-emergency admission within two business days of the date of the request. Qualified health care personnel will be available for same-day telephone responses to CSR inquiries.

HC-PAC4 11-14
V2-ET

Covered Expenses

- charges made by a Physician for professional services including office visits for pregnancy.

HC-COV26 04-10
V1-ET2

Definitions

Dependent

The term child means a child born to you or a child legally adopted by you including that child from the date of placement. Coverage for such child will include the necessary care and treatment of medical conditions existing prior to the date of placement including medically diagnosed congenital defects or birth abnormalities. It also includes a stepchild.

HC-DFS74 04-10
V1-ET1

CIGNA HEALTH AND LIFE INSURANCE COMPANY, a Cigna company (hereinafter called Cigna)

CERTIFICATE RIDER – Washington Residents

Rider Eligibility: Each Employee who is located in Washington

You will become insured on the date you become eligible, including if you are not in Active Service on that date due to your health status.

This rider forms a part of the certificate issued to you by Cigna.

The provisions set forth in this rider comply with the legal requirements of Washington group insurance plans covering insureds located in Washington. These provisions supersede any provisions in your certificate to the contrary unless the provisions in your certificate result in greater benefits.

HC-ETWARDR

Notice

Coordination of Benefits Included – See Table of Contents for Location of Coordination of Benefits Section.

HC-CER1 02-16
V11-ET

Customer Service

HIPAA Privacy Statement

Your privacy is important to us. The following website explains how we collect and protect information about you:

www.cigna.com/privacyinformation

You may also request copies of this information by contacting customer service at the number shown on your ID card

If you would like to know more about your rights under the law, or if you think anything you received from this plan may not conform to the terms of your contract or your rights under the law, you may contact the Office of Insurance Commissioner at 800-562-6900. If you have a concern about the qualifications or professional conduct of your mental health service provider, please call the State Health Department at 800-525-0127.

Notice regarding Coordination of Benefits

If you are covered by more than one health benefit plan and you do not know which is your primary plan, you or your provider should contact any one of the health plans to verify which plan is primary. The health plan you contact is responsible for working with the other plan to determine which is primary and will let you know within thirty calendar days.

CAUTION: All health plans have timely claims filing requirements. If you or your provider fails to submit your claim to a secondary health plan within that plan's claim filing time limit, the plan can deny the claim. If you experience delays in the processing of your claim by the primary health plan, you or your provider will need to submit your claim to the secondary health plan within its claim filing time limit to prevent a denial of the claim.

To avoid delay in claims processing, if you are covered by more than one plan you should promptly report to your providers and plans any changes in your coverage.

American Indian Health Services

American Indians, who are covered by this plan, may use the services of the Indian Health System under the same terms and conditions as an insured who uses in-network benefits and services.

Your Right to Safe and Effective Pharmacy Services

State and federal laws establish standards to assure safe and effective pharmacy services, and to guarantee your right to know what drugs are covered under this plan and what coverage limitations are in your contract. If you would like more information about the drug coverage policies under this plan, or if you have a question or a concern about your pharmacy benefit, please contact us (Cigna) at the number on your ID card.

If you would like to know more about your rights under the law, or if you think anything you received from this plan may not conform to the terms of your contract, you may contact the Washington State Office of Insurance Commissioner at 1-800-562-6900. If you have a concern about the pharmacists or pharmacies serving you, please call the State Department of Health at 360-236-4825.

Items to be Available on Request

You may request copies of the following documents by contacting customer service at the phone number listed on the back of your ID card, or by logging on to www.mycigna.com.

- any documents, instruments, or other information referred to in the Policy or certificate;
- Pharmacy question and answer document;
- a full description of the procedures to be followed by an insured for consulting a provider other than the primary care provider and whether the insured's primary care provider, or Cigna's medical director, or another entity must authorize the referral;
- procedures, if any, that an insured must first follow for obtaining prior authorization for health care services;
- a written description of any reimbursement or payment arrangements, including, but not limited to, capitation provisions, fee-for-service provisions, and health care delivery efficiency provisions, between Cigna and a provider or network;
- descriptions and justifications for provider compensation programs, including any incentives or penalties that are intended to encourage providers to withhold services or minimize or avoid referrals to specialists;
- an annual accounting of all payments made by Cigna which have been counted against any payment limitations, visit limitations, or other overall limitations on a insureds coverage under the plan;
- a copy of Cigna's grievance process for claim or service denial and for dissatisfaction with care; and
- accreditation status with one or more national managed care accreditation organizations, and whether Cigna tracks its health care effectiveness performance using the health employer data information set (HEDIS), whether it publicly reports its HEDIS data, and how interested persons can access its HEDIS data.
- access to and copies of all information relevant to a claim.
- the criteria, processes, strategies, evidentiary standards and other factors used to make medical necessity determinations of MH/SUD benefits and apply an NQTL to medical/surgical and MH/SUD benefits under the plan.

HC-NOT72 ET

Eligibility - Effective Date

Exception for Newborns

Any Dependent child born while you are insured for Medical Insurance will be automatically insured for Medical Insurance for the first 31 days of life. If payment of an additional premium is required to provide coverage for a child, to continue coverage beyond 31days, you must elect Dependent Medical Insurance for your newborn child within the 60 day enrollment period which begins on the first day of birth. If Dependent Medical Insurance is not elected within the 60 day enrollment period, you may be required to wait until the next plan enrollment period to enroll the child for coverage under the plan.

HC-ELG1

V25-ET

Certification Requirements

For You and Your Dependents

Pre-Admission Certification/Continued Stay Review for Hospital Confinement

If your request for Experimental and Investigational treatment is denied, Cigna will notify you in writing within 20 working days. This review period will be extended beyond 20 working days only if you provide your informed written consent to Cigna.

PAC will not be required for mental health treatment rendered by a state hospital when you [or your Dependent] are involuntarily committed.

We will not retroactively deny coverage for:

- emergency and nonemergency care that had prior authorization under the plan's written policies at the time the care was rendered; or
- care based on standards and protocols not communicated within a sufficient time for your Physician, healthcare provider or facility to modify care.

PAC and CSR are performed through a utilization review program by a Review Organization with which Cigna has contracted.

In any case, those expenses incurred for which payment is excluded by the terms set forth above will not be considered as expenses incurred for the purpose of any other part of this plan, except for the "Coordination of Benefits" section.

HC-PAC44

V1-ET

Covered Expenses

- charges made in connection with mammograms for breast cancer screening if prescribed by a Physician, an advanced registered nurse practitioner or a physician assistant.
- charges made for an annual prostate-specific antigen test (PSA) and digital rectal exam.
- charges for colorectal cancer exams and laboratory tests consistent with the guidelines or recommendations of the United States preventative services task force of the federal centers for disease control and prevention: at the frequency identified in the recommendations and guidelines, as deemed appropriate by the patients Physician advanced registered nurse practitioner, or physician assistant after consultation with the patient; and to a covered individual who is:
  - at least 50 years old; or
  - less than 50 years old, but considered high risk according to the guidelines and recommendations.
- charges made for laboratory services, radiation therapy and other diagnostic and therapeutic radiological procedures.
- charges made for a drug that has been prescribed to treat a life-threatening illness for which it has not been approved by the Food and Drug Administration (FDA). Such drug must be covered, provided: (a) it is recognized for the specific type of illness for which the drug has been prescribed in any one of the following established reference compendia: United States Pharmacopeia Drug Information; American Medical Association Drug Evaluation; American Hospital Formulary Service; other compendia identified by state or federal government; the majority of related peer-reviewed medical literature; or the Federal Secretary of Health and Human Services; (b) the drug has been otherwise approved by the FDA; and (c) the drug has not been contraindicated by the FDA for the use prescribed.
- charges incurred by a Dependent child for Medically Necessary neurodevelopmental therapies, including, speech, occupational or physical therapies when rendered by a licensed Physician. Benefits include services to restore and improve function, as well as, maintenance to prevent deterioration in the patient's condition, unless otherwise covered by the plan.
- charges made for general anesthesia services and related facility charges in conjunction with any dental procedure performed in a Hospital or Free-Standing Surgical Facility if such anesthesia services and related facility charges are Medically Necessary because the covered person:
  - is under the age of seven, or physically or developmentally disabled, with a dental condition that cannot be safely and effectively treated in a dental office; or
  - has a medical condition that the person's Physician determines would place the person at undue risk if the dental procedure were performed in a dental office. The procedure must be approved by the person's Physician.
- charges made for women's health care services. Women’s health care services include, but are not limited to, maternity care, reproductive health services, gynecological care, general examination, and preventive care as medically appropriate, and medically appropriate follow-up visits for these services.

  Coverage is provided for health care services for maternity patients and newly born children ordered by the Attending Provider. Decisions regarding the appropriate length of an inpatient stay, post delivery care and follow-up care for a mother and her newly born child will be made by the Attending Provider, in consultation with the mother. These decisions must be based on accepted medical practice and medical necessity as determined by the Attending Provider. Follow up care includes but is not limited to, the services of the Attending Provider, home health agencies and licensed registered nurses.

  The term "Attending Provider" means a provider who is working within the scope of his or her license and has clinical hospital privileges. Attending Providers include, but are not limited to: a licensed Physician; a licensed certified nurse midwife; a licensed midwife, a licensed physician’s assistant; or a licensed advanced registered nurse practitioner.
- charges made for orally administered anti-cancer medication prescribed to kill or slow cancer cell growth are

paid at the same cost share as intravenous or injectable anti-cancer drugs.

- charges for the treatment for insulin using diabetes, non-insulin using diabetes, or elevated blood glucose levels induced by pregnancy, including:
  - diabetes equipment including blood glucose monitors, insulin pumps and accessories, insulin infusion devices, foot care appliances for prevention of complications associated with diabetes;
  - diabetes outpatient self-management training and education;
- diabetes supplies including insulin, insulin needles and syringes, lancets, injection aids, test strips for glucose monitors, visual blood sugar reading and urine testing strips, prescriptive oral agents for controlling blood sugar levels, glucogen emergency kits.
- charges made for ABA therapy.
- charges made for a second a second opinion regarding any medical diagnosis or treatment plan from a qualified Participating Provider of the insured's choice.
- charges made for any health care service performed by a pharmacist if the service performed was within the lawful scope of such person's license, the plan would have provided benefits if the service had been performed by a Physician, an advanced registered nurse practitioner or a physician's assistant; and the pharmacist is included in the plan's network of Participating Providers;

Clinical Trials

This benefit plan covers routine patient care costs related to a qualified clinical trial for an individual who meets the following requirements:

(a) is eligible to participate in an approved clinical trial according to the trial protocol with respect to treatment of cancer or other life-threatening disease or condition; and

(b) either

- the referring health care professional is a participating health care provider and has concluded that the individual's participation in such trial would be appropriate based upon the individual meeting the conditions described in paragraph (a); or
- the individual provides medical and scientific information establishing that the individual's participation in such trial would be appropriate based upon the individual meeting the conditions described in paragraph (a).

For purposes of clinical trials, the term "life-threatening disease or condition" means any disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted.

The clinical trial must meet the following requirements:

The study or investigation must:

- be approved or funded by any of the agencies or entities authorized by federal law to conduct clinical trials including an IRB of an institution in the state that has an agreement with the Office for Human Research Protections at DHHS;
- be conducted under an investigational new drug application reviewed by the Food and Drug Administration; or
- involve a drug trial that is exempt from having such an investigational new drug application.

Routine patient care costs are costs associated with the provision of health care items and services including drugs, items, devices and services otherwise covered by this benefit plan for an individual who is not enrolled in a clinical trial and, in addition:

- services required solely for the provision of the investigational drug, item, device or service;
- services required for the clinically appropriate monitoring of the investigational drug, device, item or service;
- services provided for the prevention of complications arising from the provision of the investigational drug, device, item or service; and
- reasonable and necessary care arising from the provision of the investigational drug, device, item or service, including the diagnosis or treatment of complications.

Routine patient care costs do not include:

- the investigational drug, item, device, or service, itself; or
- items and services that are provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient.

If your plan includes In-Network providers, Clinical trials conducted by non-participating providers will be covered at the In-Network benefit level if:

- there are not In-Network providers participating in the clinical trial that are willing to accept the individual as a patient, or
- the clinical trial is conducted outside the individual's state of residence.

Nutritional Evaluation

Charges made for nutritional evaluation and counseling when diet is a part of the medical management of a documented organic disease.

- coverage for Medically Necessary elemental formula, regardless of delivery method, when a licensed provider with prescriptive authority diagnoses a patient with an eosinophilic gastrointestinal associated disorder and orders and supervises the use of the elemental formula.

- charges made for or in connection with phenylketonuria.

HC-COV428

V3-ET1

Home Health Services

Home Health Services are those skilled health care services that can be provided during visits by Other Health Care Professionals. The services of a home health aide are covered when rendered in direct support of skilled health care services provided by Other Health Care Professionals.

A visit is defined as a period of 2 hours or less. Home Health Services are subject to a maximum of 16 hours in total per day.

Necessary consumable medical supplies and home infusion therapy administered or used by Other Health Care Professionals in providing Home Health Services are covered. Home Health Services do not include services by a person who is a member of your family or your Dependent's family or who normally resides in your house or your Dependent's house even if that person is an Other Health Care Professional. Skilled nursing services or private duty nursing services provided in the home are subject to the Home Health Services benefit terms, conditions and benefit limitations in The Schedule. Physical, occupational, and other Short-Term Rehabilitative Therapy services provided in the home are not subject to the Home Health Services benefit limitations in the Schedule, but are subject to the benefit limitations described under Short-term Rehabilitative Therapy Maximum shown in The Schedule.

HC-COV5

V5-ET

Mental Health and Substance Use Disorder Services

Mental Health Services are services that are required to treat a disorder that impairs the behavior, emotional reaction or thought processes. In determining benefits payable, charges made for the treatment of any physiological conditions related to Mental Health will not be considered to be charges made for treatment of Mental Health.

Substance Use Disorder is defined as the psychological or physical dependence on alcohol or other mind-altering drugs that requires diagnosis, care, and treatment. In determining benefits payable, charges made for the treatment of any physiological conditions related to rehabilitation services for alcohol or drug abuse or addiction will not be considered to be charges made for treatment of Substance Use Disorder.

Inpatient Mental Health Services

Services that are provided by a Hospital while you or your Dependent are Confined in a Hospital for the treatment and evaluation of Mental Health. Inpatient Mental Health Services include Mental Health Residential Treatment Services.

Mental Health Residential Treatment Services are services provided by a Hospital for the evaluation and treatment of the psychological and social functional disturbances that are a result of subacute Mental Health conditions.

Mental Health Residential Treatment Center means an institution which specializes in the treatment of psychological and social disturbances that are the result of Mental Health conditions; provides a subacute, structured, psychotherapeutic treatment program, under the supervision of Physicians; provides 24-hour care, in which a person lives in an open setting; and is licensed in accordance with the laws of the appropriate legally authorized agency as a residential treatment center.

A person is considered confined in a Mental Health Residential Treatment Center when she/he is a registered bed patient in a Mental Health Residential Treatment Center upon the recommendation of a Physician.

Outpatient Mental Health Services

Services of Providers who are qualified to treat Mental Health when treatment is provided on an outpatient basis, while you or your Dependent are not Confined in a Hospital, and is provided in an individual, group Mental Health Partial Hospitalization or Mental Health Intensive Outpatient Therapy Program, and in the home setting for Applied Behavior Analysis when based on accepted medical practice and Medical Necessity as determined by your Provider..

Covered services include, but are not limited to, outpatient treatment of conditions such as: anxiety or depression which interfere with daily functioning; emotional adjustment or concerns related to chronic conditions, such as psychosis or depression; emotional reactions associated with marital problems or divorce; child/adolescent problems of conduct or poor impulse control; affective disorders; suicidal or homicidal threats or acts; eating disorders; or acute exacerbation of chronic Mental Health conditions (crisis intervention and relapse prevention) and outpatient testing and assessment.

Mental Health Partial Hospitalization Services are rendered not less than 4 hours and not more than 12 hours in any 24-hour period by a certified/licensed Mental Health program in accordance with the laws of the appropriate legally authorized agency.

A Mental Health Intensive Outpatient Therapy Program consists of distinct levels or phases of treatment that are provided by a certified/licensed Mental Health program in accordance with the laws of the appropriate, legally authorized

agency. Intensive Outpatient Therapy Programs provide a combination of individual, family and/or group therapy in a day, totaling nine or more hours in a week.

Inpatient Substance Use Disorder Rehabilitation Services

Services provided for rehabilitation, while you or your Dependent are Confined in a Hospital, when required for the diagnosis and treatment of abuse or addiction to alcohol and/or drugs. Inpatient Substance Use Disorder Services include Partial Hospitalization sessions and Residential Treatment services.

Substance Use Disorder Residential Treatment Services are services provided by a Hospital for the evaluation and treatment of the psychological and social functional disturbances that are a result of subacute Substance Use Disorder conditions.

Substance Use Disorder Residential Treatment Center means an institution which specializes in the treatment of psychological and social disturbances that are the result of Substance Use Disorder; provides a subacute, structured, psychotherapeutic treatment program, under the supervision of Physicians; provides 24-hour care, in which a person lives in an open setting; and is licensed in accordance with the laws of the appropriate legally authorized agency as a residential treatment center.

A person is considered confined in a Substance Use Disorder Residential Treatment Center when she/he is a registered bed patient in a Substance Use Disorder Residential Treatment Center upon the recommendation of a Physician.

Outpatient Substance Use Disorder Rehabilitation Services

Services provided for the diagnosis and treatment of Substance Use Disorder or addiction to alcohol and/or drugs, while you or your Dependent are not Confined in a Hospital, including outpatient rehabilitation in an individual, or a Substance Use Disorder Partial Hospitalization or Intensive Outpatient Therapy Program.

Substance Use Disorder Partial Hospitalization Services are rendered not less than 4 hours and not more than 12 hours in any 24-hour period by a certified/licensed Substance Use Disorder program in accordance with the laws of the appropriate legally authorized agency.

A Substance Use Disorder Intensive Outpatient Therapy Program consists of distinct levels or phases of treatment that are provided by a certified/licensed Substance Use Disorder program in accordance with the laws of the appropriate legally authorized agency. Intensive Outpatient Therapy Programs provide a combination of individual, family and/or group therapy in a day, totaling nine, or more hours in a week.

Substance Use Disorder Detoxification Services

Detoxification and related medical ancillary services are provided when required for the diagnosis and treatment of addiction to alcohol and/or drugs. Cigna will decide, based on the Medical Necessity of each situation, whether such services will be provided in an inpatient or outpatient setting.

Exclusions

The following are specifically excluded from Mental Health and Substance Use Disorder Services:

- treatment of disorders which have been diagnosed as organic mental disorders associated with permanent dysfunction of the brain.
- developmental disorders, including but not limited to, developmental reading disorders, developmental arithmetic disorders, developmental language disorders or developmental articulation disorders, unless otherwise covered by the plan.
- counseling for activities of an educational nature.
- counseling for borderline intellectual functioning.
- counseling for occupational problems.
- counseling related to consciousness raising.
- vocational or religious counseling.
- I.Q. testing.
- custodial care, including but not limited to geriatric day care.
- psychological testing on children requested by or for a school system.
- occupational/recreational therapy programs even if combined with supportive therapy for age-related cognitive decline.

HC-COV481

V2-ET

Definitions

Concurrent Care Coverage Determination

Concurrent Care Coverage Determination means a medical necessity determination that is made during the period when the health care services or supplies are being provided to a customer including a) during on-going inpatient, intensive outpatient or residential behavioral healthcare treatment, b) during ongoing ambulatory care.

HC-DFS871 ET

Dependent

Dependents are:

your lawful spouse; or

- your Domestic Partner; and
- any child of yours who is
  - less than 26 years old.
- 26 or more years old, and primarily supported by you and incapable of self-sustaining employment by reason of mental or physical disability.

  Proof of the child's condition and dependence must be submitted to Cigna within 31 days after the date the child ceases to qualify above. Cigna may require proof not more frequently than annually after the two year period following the child's attainment of the limiting age.

The term child means a child born to you or a child legally adopted by you including a child for whom you assume legal obligation for total or partial support, in anticipation of adoption, but with no requirement that the adoption be final. It also includes a stepchild. If your Domestic Partner has a child, that child will also be included as a Dependent.

Benefits for a Dependent child will continue until the last day of the calendar month in which the limiting age is reached. Anyone who is eligible as an Employee will not be considered as a Dependent spouse. A child under age 26 may be covered as either an Employee or as a Dependent child. You cannot be covered as an Employee while also covered as a Dependent of an Employee.

No one may be considered as a Dependent of more than one Employee.

HC-DFS673

V8-ET

Domestic Partner

A Domestic Partner is defined as a person who has a valid domestic partner registration in Washington.

HC-DFS47

V8-ET

Related Supplies

Related Supplies means diabetic supplies (insulin needles and syringes, lancets, injection aids, test strips for glucose monitors, visual blood sugar reading and urine testing strips, prescriptive oral agents for controlling blood sugar levels, glucogen emergency kits), needles and syringes for injectables covered under the pharmacy plan, and spacers for use with oral inhalers.

HC-DFS68

V7-ET

CIGNA HEALTH AND LIFE INSURANCE COMPANY, a Cigna company (hereinafter called Cigna)

CERTIFICATE RIDER – Wisconsin Residents

Rider Eligibility: Each Employee who is located in Wisconsin

You will become insured on the date you become eligible, including if you are not in Active Service on that date due to your health status.

This rider forms a part of the certificate issued to you by Cigna.

The provisions set forth in this rider comply with the legal requirements of Wisconsin group insurance plans covering insureds located in Wisconsin. These provisions supersede any provisions in your certificate to the contrary unless the provisions in your certificate result in greater benefits.

GM6000

HC-ETWIRDR

Termination of Insurance

Special Continuation of Medical Insurance

If your insurance ceases for any reason other than discontinuance of the policy; failure to make any required contributions; or termination of employment due to misconduct; and if you have been insured for at least three consecutive months, you may continue your Medical Insurance by paying the required premiums to the Employer. In no event will the insurance be continued beyond the earliest of the following dates:

- 18 months from the date the insurance would otherwise cease;
- the last day for which you have paid the required premium;
- the date you become eligible for similar group coverage;
- the date the group policy cancels.

If your insurance is being continued as described above, the Medical Insurance for any one of your Dependents insured on

the date your insurance would otherwise cease may be continued under the same conditions shown above, until the date your insurance ceases or, with respect to any one Dependent, the date that Dependent ceases to qualify as a Dependent, whichever comes first.

For Dependents of Deceased Employee

If you die while insured, your Dependents who are insured at the time of your death may continue their Medical Insurance by paying the required premium to the Employer, but in no event beyond the earliest of the following dates:

- 18 months from the date of your death;
- the last day for which the required premium has been paid;
- with respect to any one Dependent, the date that Dependent becomes eligible for similar group coverage; or the date that Dependent ceases to qualify as a Dependent for any reason other than lack of primary support by you;
- the date the policy cancels.

For Spouse Upon Divorce From Employee

If your spouse's Medical Insurance would otherwise terminate because of divorce or annulment of marriage, your former spouse may continue the insurance by paying the required contribution to the Employer, but in no event beyond the earliest of the following dates:

- 18 months from the date the insurance would otherwise cease;
- the last day for which the required contribution has been paid;
- the date that your former spouse becomes eligible for similar group coverage;
- the date you are no longer insured under the policy;
- the date this policy cancels.

If the insurance on your former spouse is being continued under a group policy that was replaced by this policy, such spouse will be eligible for continuance under this policy, subject to the other provisions of this policy. However, the insurance will not be continued beyond a period of time totaling more than 18 months under both policies combined.

Notification of Special Continuation

The Employer will notify in writing any eligible person, within five days after the date that person's insurance would otherwise cease, of his right to elect the continuation. The eligible person may elect the continuation by applying in writing and sending the required contribution to the Employer within 30 days after the day he receives written notice of his option to continue his insurance.

Conversion Available Following Continuation

The terms of the "Medical Conversion Privilege" section will apply following the termination of insurance.

The terms of this section will not reduce any continuation of insurance otherwise provided.

HC-TRM59 04-10
V1-ET

Definitions

Grievance

The term Grievance means any written dissatisfaction by you or your Dependent with Cigna's administration, claims practices or provision of services.

HC-DFS221 04-10
V1-ET

CIGNA HEALTH AND LIFE INSURANCE COMPANY, a Cigna company (hereinafter called Cigna)

CERTIFICATE RIDER – Wyoming Residents

Rider Eligibility: Each Employee who is located in Wyoming

You will become insured on the date you become eligible, including if you are not in Active Service on that date due to your health status.

This rider forms a part of the certificate issued to you by Cigna.

The provisions set forth in this rider comply with the legal requirements of Wyoming group insurance plans covering insureds located in Wyoming. These provisions supersede any provisions in your certificate to the contrary unless the provisions in your certificate result in greater benefits.

HC-ETWYRDR

Covered Expenses

- charges for cancer screening tests, including: a pelvic examination, Pap smear and clinical breast cancer examination, including a mammogram; a prostate examination and laboratory tests; and a colorectal cancer examination and laboratory tests for any nonsymptomatic person.

HC-COV160 04-10

V1-ET1